STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS

287 West Street
Rocky Hill, Connecticut 06067

Dear Veteran,
Thank you for your interest in seeking admission to the Connecticut Department of Veterans' Affairs. Enclosed is an admission application for the Health Care Center (HCC) and the Residential Facility (RF).

Guidelines for Submitting an Application (revised June 2013)

In order to process the application, each of the following requirements must be met:

1. Enclose a copy(s) of your DD FORM 214 – Certificate of Release or Discharge from Active Duty, which lists your place of entry and place of discharge, date of entry and discharge, record of service, time lost, and character of service**. If you served more than one period please submit a copy of each DD214 you have received.** A DD214 must be furnished to us even if you have been here in the past. If you do not have a DD Form 214 – follow instructions on the enclosed Standard Form 180 (SF180) and mail it to the designated area listed.

2. Proof of Connecticut (CT) Residency – General Statutes of Connecticut Revised January 1, 2009, Volume 9, Section 27– Armed Forces and Veterans, General Provisions Section 27-103(b) states "veteran" means any veteran who served in time of war, as defined in subsection (a) of this section, and who is a resident of this state, provided, if he was not a resident or resident alien of this state at the time of enlistment or induction into the armed forces, he shall have resided continuously in this state for at least two years.

3. Enclose a copy of your Health Insurance Card(s) – VA CT Healthcare System card (Newington or West Haven Campus), Medicare, Medicaid Title XIX card and/or other health insurance cards you have.

4. Physician to complete the enclosed Medical Certificate on Pg. 11 & 12.

5. Complete and sign the application along with the following forms:
   - Release of Information Form (State of CT DVA)
   - Request for and Authorization to Release Info (Federal VA Form 10-5345)
   - Billing Information Form
   - Income Assets Questionnaire
   - Application for Health Benefits (VA Form 10-10EZ)

   Omissions, false information, or lack of sufficient detail, will result in the delay or denial of the processing of your application.

6. Your application will be delayed until this information is received. Please make an appointment with your Primary Care Provider at VA CT Healthcare System (Newington or West Haven Campus) to obtain the following information:
   a. Name of Primary Care Provider at VA CT Healthcare System
   b. A current PPD or chest x-ray, and lab report
   c. A current psychiatric and substance abuse assessment
   d. A current medical assessment and list of medications
   e. Application for Health Benefits (10-10EZ) Form

Guidelines for Submitting an Application (continued)

7. Enclose a copy of the Probate Court document – if a Conservator and/or Power of Attorney has been appointed for you.

8. Enclose a copy of a Living Will if you have one, enclose a copy of your assigned Health Care Agent and/or a Durable Power of Attorney document(s) if applicable.

9. Enclose a copy of any Legal Dispositions - Recent court cases or current terms/conditions of Probation/Parole.

10. Meet criteria for admission outlined on page 3.

Please be advised that a date for admission will not be considered until all documents are submitted and the application is reviewed and approved.

For Health Care Center

Questions concerning the application or application process for Long Term or Respite Care in the Health Care Center, contact the HCC Admissions Office (860) 616-3705

Fax application to:
(860) 616-3545

Mail application to:
HCC Admissions Coordinator
Department of Veterans' Affairs
287 West Street
Rocky Hill, CT 06067

For Residential Facility

Questions concerning the application or application process for the Domicile in the Residential Facility, contact the RF Admissions Office (860) 616-3802

Fax application to:
(860) 616-3556

Mail application to:
RF Admissions Coordinator
Department of Veterans' Affairs
287 West Street
Bldg. 3, Rm. 104
Rocky Hill, CT 06067

ADMISSIONS CRITERIA

THE FOLLOWING GENERAL STATEMENTS APPLY:

1. Submit completed application.

2. A veteran must have received an honorable discharge or general under honorable discharge from the Armed Forces of the United States. Veterans with a dishonorable discharge are not eligible for admission.

3. A veteran must meet all other legal requirements as outlined in the Connecticut statutes.

4. (For Residential Facility - RF) – the veteran must be able to ambulate without assistance; require no nursing or attendant care, must be able to take own medication; shower and dress without assistance; make own bed and participate in an assigned therapeutic activity.
(For Health Care Center - HCC) – the veteran must require 24 hour medical nursing care.

5. For admission to the RF or HCC – A medical certificate is enclosed for veteran's Primary Care Provider to complete.

6. In addition to the completed application, a veteran may be required to complete a medical, psychiatric, or substance abuse prescreen by our clinicians before a final determination for admission can be made.

7. Each veteran will be charged for care provided. Ability to pay for care is determined by the Department of Veterans' Affairs Regulations. See page 19.

8. Any applicant who meets the above eligibility criteria, but has been denied admission has the right to appeal in writing to the Commissioner within 10 days of notification.

SOME IMPORTANT FACTS IF ADMITTED TO THE RESIDENTIAL FACILITY (RF)

- **The Connecticut Department of Veterans Affairs will be a Smoke and Tobacco-Free Facility effective June 1, 2014.**

- All applicants will be subject to a Police Background Check.

- If admitted to the RF, motor vehicles are not allowed on grounds for ninety (90) days; Motor Vehicles are not allowed if admitted to HCC.

- A monthly billing fee will be determined upon admission. If allowed admission, any outstanding balance for a previous admission, you will be required to sign a condition agreement outlining a payment agreement.

- In general once admitted to the RF, no authorization to leave the grounds will be permitted until the entire check in procedure is completed. (Minimum of one (1) week).

- Upon admission, you will be expected to sign and agree to comply with a 90-day probationary agreement. Any violation of the agency rules and regulations may result in involuntary discharge.

Connecticut Department of Veterans' Affairs
287West Street
Rocky Hill, Connecticut 06067

Application for Admission

PLEASE FILL OUT EACH SECTION COMPLETELY

Have you ever been a resident at the CT DVA Health Care Center or Residential Facility? ☐ Yes ☐ No **(Please check)**

Application for Admission to: ☐ Long Term Care ☐ Respite ☐ Residential **(Please check one)**

Section 1 - PERSONAL DATA

Last Name _____ First Name _____ Middle Name _____
Others Names/s used _____ Maiden Name (if applicable) _____
Home Address _____ Apt. Number _____
City _____ State _____ Zip _____ County _____
Home Phone ( ) _____ Work Phone ( ) _____
Cell Phone ( ) _____ Fax # ( ) _____
Pager # ( ) _____ E-mail Address _____

Gender: Male ☐ Female ☐ Are you Spanish, Hispanic, or Latino? ☐ Yes ☐ No

What is your race? (You may check more than one.) (Information is required for statistical purposes only.)
☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander
Place of Birth (City and State) _____
State of Connecticut Resident from _____ to _____
Social Security Number ___/___/___ Date of Birth (**mm/dd/yyyy)** ___/___/___
VA Claim Number _____ Religion _____
Current Marital Status: (Check one) ☐ Married ☐ Never Married ☐ Separated
☐ Widowed ☐ Divorced ☐ Unknown

Section 2 – CURRENT LOCATION

Are you currently living at your home address? ☐ Yes ☐ No
If you are not staying at your home address, where are you staying now?
☐ Shelter ☐ Substance Abuse Treatment Facility ☐ Hospital ☐ Rest/Nursing Home
☐ With Family/Friends ☐ Other (Explain) _____

Name of Facility _____
Contact Person _____ Title _____ Phone # ( ) _____
Address _____ How Long at this Address? _____

Name _____ **Last 4 Digits of Social Security #** _____

Section 3 – REASON FOR ADMISSION

Why are you seeking admission to the Connecticut Department of Veterans Affairs?

Section 4 – MILITARY SERVICE

Date Entered Active Duty _____ Place of Entry _____
Date of Separation _____ Place of Separation _____
Branch of Service _____ Military Service Number _____
Rank _____ Pay Grade _____
Character of Service ☐ Honorable ☐ Under Honorable Conditions ☐ Medical ☐ Other (Explain)

Did you re-enlist and were issued more than one DD214? ☐ Yes ☐ No **If yes, provide copies.**
Name you served under if different from your current name _____
Check yes or no for each of the following questions:
Are you a Purple Heart recipient? ☐ Yes ☐ No
Are you a former prisoner of war? ☐ Yes ☐ No
Do you have a VA service connected rating? ☐ Yes ☐ No If yes, what %
For what condition(s) _____
VA Claim # _____ Did you serve in combat after 11/11/1998? ☐ Yes ☐ No
Was your discharge from the military for a disability incurred or aggravated in the line of duty? ☐ Yes ☐ No
Are you receiving disability retirement pay instead of VA compensation? ☐ Yes ☐ No
Do you need care of conditions potentially related to service in SW Asia during the Gulf War? ☐ Yes ☐ No
Were you exposed to Agent Orange while serving in Vietnam? ☐ Yes ☐ No
Were you exposed to radiation while in the military? ☐ Yes ☐ No
Do you have a spinal cord injury? ☐ Yes ☐ No
Do you receive a VA pension? ☐ Yes ☐ No If yes, provide VA Claim # _____
Name of Service Officer _____ Phone # _____
Have you been seen at a VA Health Care Center? ☐ Yes ☐ No If yes, provide VA # _____

Name _____ **Last 4 Digits of Social Security #** _____

Section 5 – CONSERVATORSHIP/POWER OF ATTORNEY

Has a Probate Court appointed someone as your conservator ☐ Yes ☐ No (complete information below and enclose a copy of decree)

If Yes, in which Probate Court was the Appointment made _____

Is this Appointment for ☐ Person ☐ Estate ☐ Both Effective date _____

Does anyone hold Power of Attorney for you: ☐ Yes ☐ No

CONSERVATOR		**POWER OF ATTORNEY**	
Name		Name	
Relationship		Relationship	
Street		Street	
Apartment #		Apartment #	
City		City	
State	Zip	State	Zip
Home Phone		Home Phone	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
Fax #		Fax #	
Email Address		Email Address	

Section 6 – ADVANCE DIRECTIVES AND SURROGATE DECISION MAKER

Advance Medical Directives are NOT a condition of admission. However, if you have already executed an Advance Medical Directive, a copy will be needed upon admission.

Have you appointed a Durable Power of Attorney for Healthcare (DPOA)? ☐ Yes ☐ No (**Please enclose copy)**

(The DPOA for Health Care Decisions is appointed only to make medical decisions other than withholding or withdrawal of life support systems on behalf of the patient. If there is more than one DPOA, please note if they serve jointly or separately. Note: Not all Power of Attorney appointments include Health Care.)

Have you appointed a Health Care Agent? ☐ Yes ☐ No **(please enclose copy)**

(The Health Care Agent is appointed only to convey the patient's wishes concerning the withholding or withdrawal of life supports if the patient is unable to understand and communicate informed consent regarding treatment.)

Have you appointed a Health Care Representative? ☐ Yes ☐ No **(please enclose copy)**

Organ/Tissue/Body Donor - ☐ Yes ☐ No

Next of Kin		Relationship	
Street Address		Home Phone	
City	Zip	Cell Phone	
Email Address		Work Phone	
Fax #		Pager	

Emergency Contact		Relationship	
Street Address		Home Phone	
City	Zip	Cell Phone	
Email Address		Work Phone	
Fax#		Pager	

Name _____ **Last 4 Digits of Social Security #** _____

Section 7 – EDUCATION AND EMPLOYMENT

Education (Highest Grade Completed) _____ Occupation _____
Employment: Are you currently employed? □ Yes □ No
□ Full Time □ Part Time □ Retired Date of Retirement (mm/dd/yyyy)

Name of Employer _____
Address _____
Phone # _____

Section 8 – FAMILY AND SPOUSAL INFORMATION

Mother's Maiden Name _____ Father's Name _____
Mother's Place of Birth_____ Father's Place of Birth _____
_____ Living _____ Deceased _____ Living _____ Deceased
Marital Status _____ Never Married _____ Married (1,2,3,4) _____ Divorced _____Separated _____Widowed
Spouse's Name (Last, First, Middle Name) _____
Spouse's Maiden Name _____
Address (Street, City, State, Zip _____
Phone # (_____) _____ Spouse's Date of Birth (mm/dd/yyyy) _____
Spouse's Social Security _____ Date of Marriage # (mm/dd/yyyy) _____
Spousal Employment Status _____ full time _____ part time _____ not employed _____ retired
If employed, provide company name, address, and telephone #
_____
_____
How many children do you have? _____ # Adults _____ # Minors _____
For minor dependent children, please provide Name (Last, First, Middle Name), Relationship to you, Social Security #, Date of birth (mm/dd/yyyy), and Address (Street, City, State, Zip)
_____
_____
If your spouse or dependent child did not live with you in the past year, amount you contributed to support
_____

Name _____ **Last 4 Digits of Social Security #** _____

Section 9 – MEDICAL INFORMATION

Please answer all questions below.	**Yes**	**No**
Are you able to climb stairs without help? If not, please explain.		
Are you able to shower/bathe without help? If not, please explain.		
Are you able to feed yourself without help? If not, please explain.		
Are you able to dress without help? If not, please explain.		
Do you sometimes lose control of your urine or bowels? If yes, please explain.		
Do you use a cane? If yes, please explain.		
Do you use a walker? If yes, please explain.		
Do you use crutches? If yes, please explain.		
Do you use a scooter? If yes, please explain		
Do you have difficulty remembering to do things? If yes, please explain.		
Have you ever been told that you have trouble with your heart or blood pressure? If yes, please explain.		
Have you ever been told that you have problems with your kidneys? If yes, please explain.		
Do you have trouble breathing? If yes, please explain.		
Do you use a BI-PAP machine?		

Name _____ **Last 4 Digits of Social Security #** _____

Section 9 – MEDICAL INFORMATION (continued)

Please answer all questions below.	**Yes**	**No**
Do you use a CPAP machine?		
Are you on Oxygen Therapy?		
Have you ever had a seizure? If yes, please explain.		
Do you have night sweats, cough or weight loss? If yes, please explain.		
Have you ever had Tuberculosis (TB)? If yes, please explain.		
Have you ever been told that you have PTSD? If yes, please explain.		
Do you have trouble controlling your anger? If yes, please explain.		
Have you had any problems with depression? If yes, please explain.		
Have you ever been told you have a Psychiatric illness? If yes, please explain.		
Have you ever had thoughts of harming yourself? If yes, please explain.		
Have you ever had thoughts of harming another person? If yes, please explain.		
Where do you go now for your medical care?		
Have you been hospitalized in the past 5 years? If yes, when, where, and for what reason.		

Name _____ **Last 4 Digits of Social Security #** _____

Section 9 – MEDICAL INFORMATION (continued)

MEDICATIONS

What medications do you take or should you be taking?	Dose	How often do you take this medication?

Section 10 – SUBSTANCE ABUSE & RECOVERY SUPPORT INFORMATION

Please answer all questions below.	Yes	No
Have you ever taken drugs or alcohol or been told that you have a substance abuse problem? If yes, please explain.		
Have you ever attended a program for drug or alcohol abuse? If yes, when and where?		
Are you attending a substance abuse program now? When did you start? When will you complete it? Where is it located?		
Are you interested in participating in our Recovery Support Services to assist you with your ongoing substance abuse recovery?		

If you receive your care from the VA Connecticut Healthcare System, the name and signature of your Primary Care Physician is required.

"This person will continue to be eligible for care within the VA Connecticut Healthcare System"

Printed Name of Primary Care Provider	Signature of Primary Care Provider	Date

MEDICAL CERTIFICATE

Veteran's Name: _____ Date of Birth:_____
Last 4 Digits of Social Security # _____

1. History of Present Illness / Chief Complaints:

_____
_____

2. Past Medical History (including any surgery w/ dates)

_____
_____

3. Review of Systems (circle and/ or explain)

Cough_____ Abdominal Pain_____Extremities_____Mental Status_____
Dyspnea_____ Vomiting_____ Skin_____ Vision_____
Chest Pain_____ UTI/ frequency_____ Dentures_____ Hearing_____
Substance Abuse_____ Other_____ Other_____

4. Allergies : _____

5. Physical Exam: P _____ R _____ B/P _____/_____ T _____ Wgt _____Ht_____

Check	Normal	Abnormal	Positive Findings
General			
Head - Eyes/Ears/Mouth			
Chest/ Breast			
Lungs			
Heart/ Vascular			
Abdomen/ Rectum			
Genitalia/ Pelvic			
Extremities/ Back			
Neurologic			
Skin/ Other			

6. Laboratory Studies:

X-Ray_____ EKG:_____

Blood Tests: WBC_____ HBG_____ HCT_____ PLT_____ FBS_____ K_____
CRT_____ BUN_____ Other:_____(ie. PSA, TSH, Electrolytes etc)

7. PPD & Influenza and Pneumococcal Vaccinations

Annual PPD is required

Date of PPD:_____ Date read:_____ Test Result:_____
If positive, Treatment: _____
If positive/ no treatment, please explain:_____
Date of Influenza vaccination_____ Date of Pneumococcal vaccination _____

Name _____ **Last 4 Digits of Social Security #** _____

8. Diagnoses

Diagnosis/Problem	Plan of Care

9. Medications: (should reasonably reflect diagnoses)

Medication Name & Dosage	Directions:

10. History of Infectious Diseases **Has the patient had any of the following:**

TB		HEPATITIS		CHICKEN POX		OTHER:_____		OTHER:_____	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

If any of the above are checked, please explain:_____

11. Other Problems: (ex. MRSA colonization or Vancomycin Resistive Enterococcus) Please specify:
_____

12. Mental Status: ___Alert ___Slightly Confused ___Moderately Confused ___Very Confused ___Euphoric ___Depressed ___Hallucinations ___Paranoia ___Forgetful ___ Mentally competent? ___yes ___no

13. Activity Status: ___bed rest ___bed to chair ___limited ___as desired ___as tolerated

14. Transfer: ___Independent ___Supervise ___Assist ___Unable

15. Ambulation: ___Independent ___Supervise ___Assist ___Unable Can climb stairs? ___Yes ___No ___Wheelchair ___Cane ___Walker

16. Nutritional Status: ___Overweight ___Underweight ___Malnourished ___Adequate ___Tube Diet:_____

17. Devices: ___eyeglasses ___contact lenses ___dentures ___hearing aide/s

18. Fall risk: ___low ___moderate ___high ____ non-applicable

19. Special Instructions/Concerns: _____

Examined by_____ **MD** **Date:**_____
Address:_____
_____ Phone # _____

Name _____ **Last 4 Digits of Social Security #** _____

Section 11-INSURANCE INFORMATION

Are you covered by health insurance? (including coverage through a spouse or another person) □ Yes □ No

Name of Policy Holder _____ Policy Number _____

Group Code _____

Health Insurance Company's Name, Address (Street, City, State, Zip), and Telephone Number

_____

_____

Are you eligible for Medicaid? □ Yes □ No Medicaid # _____

Have you applied for Medicaid? □ Yes □ No Date Applied: _____

Are you receiving Medicaid? □ Yes □ No

Case Worker's Name _____ Case No. _____

Are you enrolled in Medicare Hospital Insurance Part A? □ Yes □ No

Effective Date (mm/dd/yyyy) _____

Are you enrolled in Medicare Hospital Insurance Part B? □ Yes □ No

Effective Date (mm/dd/yyyy) _____

Medicare Claim Number _____

Name exactly as it appears on your Medicare Card

_____

Is need for care due to an accident? (Check one) □ Yes □ No

Is need for care due to on the job injury? (Check one) □ Yes □ No

Name _____ **Last 4 Digits of Social Security #** _____

Section 12 –LEGAL HISTORY

OMISSIONS OR FALSIFICATIONS MAY AFFECT ADMISSION

1. Have you ever been convicted of a felony: ☐ Yes ☐ No If Yes, complete the remainder of this question listing all convictions and index the Degree (1st, 2nd, etc) and the date of the conviction and the office of jurisdiction.

Felony Charge	Date of Conviction	Place of Conviction	Court of Jurisdiction
l.			
2.			
3.			
4.			

Use a separate sheet of paper to list any additional felonies.

Describe the circumstances of each felony charge and provide a copy of the police report and court documents.

2. Are you currently on probation? ☐ Yes ☐ No If yes, when does your probation end?_____,
   Legal charge(s) that your on probation for? _____
   _____

3. Are you currently on parole? ☐ Yes ☐ No If Yes, when does your parole end? _____.
   Legal charge(s) that your on parole for? _____

4. Please list the name of your probation/parole officer and the telephone number where they can be reached._____

*******ENCLOSE A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE – YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT ONE. ***

Name _____ **Last 4 Digits of Social Security #** _____

Section 12 - Legal History (continued)

4. Are there any outstanding warrants for your arrest? □ Yes □ No If yes, please explain.

5. Have you ever been convicted of any other legal charges (misdemeanor, etc.)? □ Yes □ No If yes, please explain.

6. Have you been arrested for any offenses that have not yet been resolved in Court? □ Yes □ No
   If "Yes", please explain.

7. Have you ever been incarcerated? □ Yes □ No If "Yes", please explain.

   Where:
   When:
   Length of Time:

RELEASE OF INFORMATION

Veteran's Name _____ Date of Birth _____/_____/_____

Social Security Number _____-_____-_____ VA Claim Number _____

I HEREBY AUTHORIZE THE STATE OF CONNECTICUT, DEPARTMENT OF VETERANS' AFFAIRS, TO OBTAIN INFORMATION FROM:

1. VA Connecticut Medical Centers, Newington and West Haven, CT
2. US VA Regional Office, Newington, CT
3. Other Treatment Facilities (List)

_____

INFORMATION TO BE DISCLOSED: (Initial each item that applies):

_____ Copy of complete health records including outpatient, E.R., hospitalization
_____ Alcohol Abuse
_____ Drug Abuse
_____ Psychiatric
_____ Sickle Cell
_____ On-going communication (telephonic/written/faxed)
_____ Military Service

I authorize the Connecticut Department of Veterans' Affairs to release/obtain all pertinent information regarding my treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/AIDS, and Sickle Cell to/from such facilities as necessary for the admissions process and any treatment and care.
For release of information, this authorization will automatically expire ninety (90) days from the date below.
This facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized therein.
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 38CFR) and/or state law. The Federal rules and/or state law prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2 and/or state law. A general authorization for the release of medical or other information is NOT sufficient information to criminally investigate or prosecute any alcohol or drug abuse patient.

X_____ Date _____
Signature of Veteran or Conservator of Person

Name _____ **Last 4 Digits of Social Security #** _____

PLEASE READ CAREFULLY BEFORE SIGNING

1. I agree that upon admission I will obey the rules and regulations of the Connecticut Department of Veterans' Affairs. A copy will be provided to you upon admission.

2. For Admissions to the Residential Facility, I understand there is a 90-day Probationary period. I am expected to comply with all rules and regulations. Any violation may result in discharge.

3. I understand and agree that I shall pay for care provided to me and that I will comply with medical care as determined by the medical staff at this facility. Read below the Fiduciary Responsibilities according to Regulations CT State Agencies Section 27-102/d: (Amended October 11, 2007).

Sec. 27-102/(d)-253 Fiduciary duties

(2) If a veteran is or may be eligible for a third party payment, including federal veterans' benefits, Medicaid and Medicare, based on a means test or other qualifying criteria, the department shall take actions designed to ensure initial and continued eligibility for such benefits and programs.

Sec. 27-102/(d)-254 Liability for services rendered

(a) Each veteran or his legally liable relative shall be liable for the cost of services rendered, except as otherwise provided in the Regulations of Connecticut State Agencies and state or federal law(s). A presumption shall exist that a veteran can pay in full for all services rendered. The burden is at all times on the veteran to demonstrate that he is without ability to pay.

Sec. 27-102/(d)-259Third Party benefits

(a) The Department may execute and maintain agreements with other public agencies and private entities to participate in reimbursement programs, including but not limited to Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act and the United States Department of Veterans' Affairs.

(b) Each veteran who the Commissioner determines may be eligible for reimbursements from a third party insurer of governmental program is obligated to provide necessary information and fully cooperate with the Department in the application for and maintenance of such income reimbursement or benefit. Failure to comply with this subsection shall be grounds for involuntary assignment of income and assets or involuntary discharge.

(c) For any program administered by the Department of Veterans' Affairs for which the Department is a Medicaid provider and for the purposes of determining order of liability, the state Department of social services through the Medicaid program shall be "payor of last resort" and all other payment sources shall be exhausted before any bill is presented to the Department of Social Services.

(d) For any program administered by the Department of Veterans' Affair for which the Department is a Medicaid provider and in the event that a portion of the regulations of Connecticut state agencies is in conflict with the Department of Social Services' Uniform Policy Manual as amended from time to time, the Department of Social Services regulation shall prevail.

(e) The veteran shall, or shall cause his representative to, promptly file and claim income, assets, and reimbursement due and owed, or available to the veteran for payment of or reimbursement of expenditures made on his behalf or which may be claimed for services rendered to him. Sources covered by this subsection include, but are not limited to private insurance, a trust or any other arrangement under which the veteran is or could be a beneficiary, whether specifically named or not.

(f) The veteran shall cooperate in any action, including making application, or preceding that can or may be brought for the purpose of making the veteran's income, asset or reimbursement available to meet the costs of his care. In the event that the veteran refuses or fails to cooperate in such efforts, the Commissioner may:

(1) Apply for a conservatorship to accomplish these tasks;
(2) Consider the failure to comply with the regulations of Connecticut state agencies as a ground for involuntary assignment of the same; or
(3) Initiate proceeding for involuntary discharge.

Name _____ **Last 4 Digits of Social Security #** _____

PLEASE READ CAREFULLY BEFORE SIGNING (Continued)

4. I understand and agree that in the event of my death, the Commissioner may make a claim against my estate for the cost of care provided to me.

5. I understand and agree that I am solely responsible for any money, clothing, jewelry, or other valuables retained by me while a resident of this facility.

6. **RELEASE OF INFORMATION** - I consent that any physician, primary care provider, surgeon, dentist or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to this facility, any information about myself, and I waive any privilege which renders such information confidential. I consent to a check of my history, if any, by the Department of Public Safety, Division of State Police.

I HAVE READ THIS FORM AND I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

X_____
Signature of Veteran or Conservator of Person

_____
Signature of Witness

cc: Veteran

Name _____ **Last 4 Digits of Social Security #** _____

Billing/DVA Cost of Care Information

Cost of care is determined by the facility/level of care program the veteran is admitted to: Residential Facility or Health Care Center.

Residential Facility:

The cost of care is determined by the length of stay. However, in extreme financial hardship, the Department of Veterans' Affairs will waive the cost of care for veterans in need with proper documentation/ verification of assets and service connectivity.

LEVEL:	Length of Stay	**Monthly Billing Rate**
1	**0 to 3 months**	**$0.00**
2	**4 to 36 months (3 years)**	**$200.00**
3	**>37 months**	**$300.00***

****subject to periodic review at the Commissioner's discretion. The proposed revision for level 3 is effective January 1, 2014.***

Health Care Center:

The cost of care is determined by the *current* allowable Medicaid rate.

- According to Connecticut General Statute (CGS) 27-108: If unable to pay healthcare costs, the veteran is required to have a completed and filed "pending" Medicaid (a/k/a Title XIX) application. The financially responsible party is required to pay charges assessed by DVA until such time the veteran is eligible for Medicaid. Once Medicaid eligibility is determined, Medicaid assumes the primary responsibility for paying the veteran's cost of care; however, the veteran remains responsible for contributing their "applied income" towards the cost of care as computed by Department of Social Services.
- *Or* if the veteran has a 70% or more Service Connected Disability; provided eligibility criteria is met; the veteran may opt to have the Federal Department of Veterans' Affair assume the primary responsibility for paying the veteran's cost of care to the State DVA.

Respite Care:

Respite care is a program to give a primary care giver a temporary break ("respite").
There is no fee for this program; however the care is limited to a minimum of five (5) days to a maximum of twenty-eight (28) days in any twelve (12) month period. As per CGS 27-102l(d)108 (J): Should the care giver be unable or unwilling to *resume* the role of primary care giver, then a discharge placement plan must be presented, other than admission to a DVA departmental program.

To find out the *current* Medicaid rate and if you have any questions related to the billing process or any billing policies, please contact one of the Billing Office Staff listed below:

Elizabeth Syska – Fiscal Administrative Supervisor – (860) 616-3644
Linda Turgeon – Fiscal Administrative Officer - (860) 616-3645
Susan Amenta - Fiscal Administrative Officer - (860) 616-3646

Name _____ **Last 4 Digits of Social Security #** _____

INCOME INFORMATION SHEET

You will be responsible for paying your bill based on the current Department of Veterans' Affairs regulations. Any questions regarding "How the Billing is handled", please contact the Billing Office (860) 616-3644.

Please provide the <u>current</u> monthly amounts you receive from the sources below:

1. Social Security Disability _____
2. Social Security Retirement _____
3. VA Pension _____
4. VA Compensation _____
5. FT/PT Employment _____
6. Other (pensions, VA Educational Stipends, etc.) _____

I attest the above information is accurate to the best of my knowledge. I authorize the Department of Veterans' Affairs to verify the information provided.

Failure to provide accurate information will result in discharge from the Veterans' Home. Please remember we need full cooperation from everyone, in order for this program to be successful. Thank you.

Printed Name	Signature	Date

Last 4 Digits of Social Security # _____

STATE OF CONNECTICUT/DEPARTMENT OF VETERANS' AFFAIRS

INCOME/ASSETS QUESTIONNAIRE (IA)/DVA CASE#: _____

Instructions: **Please complete form in its entirety**. If no Income or Assets are indicated, please fill in each area with a zero. In addition, **please initial each section; sign and date at the end of this form**. According to Connecticut General Statue 27-108 such veterans who are able to pay in whole or in part for services are required to pay their cost of care based on their ability to pay. If unable to pay, those entering the hospital are required to have a completed and filed "pending" Medicaid (Title XIX) application. The veteran and/or responsible party are required to provide full disclosure of all financial information in accordance with CGS 27-117. If there is a pending Medicaid application, the veteran and/or responsible party are required to continue paying the charges assessed by the DVA pursuant to CGS 27-108 until such time as The Department of Social Services (DSS) determines that the veteran is eligible for assistance. Once Medicaid eligibility is determined, Medicaid assumes the primary responsibility for paying the veteran's care at the hospital; however, the veteran remains responsible for contributing his/her "applied income" towards the cost of care as computed by DSS pursuant to its administration of the Medicaid program.

Veteran's Name:		Spouse's Name:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	

Type of Income/ Acct # (If applicable)	Source of Income Address (if applicable)	Veteran Amount	Spouse Amount	Frequency
Social Security	Social Security Administration			Monthly
VA Pension.Comp.	U.S. Department of Veterans' Affairs			Monthly
Retirement/Pension				
Retirement/Pension				
Dividends/Interest Account #:				
Rental Property Income				
Other (describe)				

Type of Asset ID # (if applicable)	Location of Asset Name/Address/Phone (if applicable)	Veteran Amount	Spouse Amount
Savings Account Account #:			
Savings Account Account #:			
Checking Account Account #:			
Checking Account Account #:			
Certificate of Deposit Account #:			
Stock Certificate Number(s):			
Bonds Certificate Number(s):			
Prepaid Funeral Contract #:			
Life Insurance Policy Policy #:			
Motor Vehicle VIN Number #:			
Real Estate Address:			
Other Asset Account ID #:			

IA/DVA QUESTIONNAIRE (Continued)

Name _____ **Last 4 Digits of Social Security #** _____

Case # _____

COURT- ORDERED OBLIGATION INFORMATION (Note: Court Documentation is required)

TYPE OF OBLIGATION	Paid to (Name/Address)	Veteran Amount	Spouse Amount	Frequency
Alimony				
Child Support				
Other:				

COURT- ORDERED OBLIGATION INFORMATION

TYPE OF HOUSEHOLD COST	Paid to (Name/Address)	Veteran Amount	Spouse Amount	Frequency
Rent				
Mortgage				
Rental/Mortgage Insurance				
Real Estate Tax				
Other (identify)				

FINANCIAL RELATIONSHIP TO VETERAN: (Please check one)

☐ Self ☐ Power of Attorney ☐ Conservator of Estate *Probate Court:*_____ *Appointment Date:*_____

(Jurisdiction)

I certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that I am required to provide this information completely and accurately according to the Connecticut General Statutes (CGS) 27-117. I also understand that I am responsible for paying for the cost of my care at the Department of Veterans'Affairs (DVA), and that I will be assessed monthly charges based on my ability to pay as per CGS 27-108 and DVA regulations. I understand that paying the assessed charges may result in the depletion of my resources. If I reside in the Health Care Center, I understand that I am required to apply for the Title XIX Medicaid benefits upon request, and to take all steps reasonably necessary to obtain Medicaid eligibility. If I apply for Title XIX benefits, I understand that I am responsible to continue paying for my portion of the cost of care as assessed by the Department of Veterans' Affairs pursuant to CGS 27-108 until such time as Title XIX is granted. If Medicaid eligibility is determined by the Department of Social Services, I understand that I am then responsible for contributing my "applied income" towards the cost of care, as computed by the Department of Social Services.

SIGNATURE:_____ DATE:_____